WASHINGTON FOCUS

June 2010

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES • DIVISION OF BEHAVIORAL HEALTH AND RECOVERY

New Outdoor Advertising Restrictions in Effect for Alcohol

By the Washington State Liquor Control Board

New alcohol advertising regulations went into effect April 3, 2010, that restrict the number and size of outdoor alcohol advertising at all liquor-licensed retail businesses statewide. The rules were adopted March 3, 2010, by the Washington State Liquor Control Board (LCB).

The outdoor advertising restrictions follow a lengthy rule-making process that involved extensive input from citizens and stakeholders such as the alcohol prevention community and industry groups.

"The Board heard testimony from all sides of this issue," said Board Chair Sharon Foster. "In the end, the advertising rules are a middle-ground solution that will reduce kids' exposure to alcohol advertising."

When the LCB opened its rulemaking process and invited public input, a flood of emails, letters, and phone calls came in seeking restrictions that reduce the amount of exposure kids see daily. Later, at a public hearing held at LCB headquarters, the Board heard from a full house of students, professionals, and concerned citizens who traveled from locations across the state to testify in favor of the proposed advertising rules.

"This is the strongest outpouring of effort on a public policy issue that I've ever seen from the alcohol prevention community," said Michael Langer, Co-chair of the Washington State Coalition to Reduce Underage Drinking (RUaD).

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*In*Side FOCUS

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Susan N. Dreyfus

DBHR Director
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FROM THE DIRECTOR

2010 Legislative Session
Broad support for our work

After a long Special Session, the Legislature adjourned with a newly adopted budget. As the implementation of many of the budget provisos is yet to be worked out, I will report on the budget itself in the next issue of Focus. Suffice it to say for now that most of the cuts proposed in the Governor's budget for chemical dependency and mental health have been restored. However, the cuts that remain will have a significant impact on specific services, such as prevention/early intervention specialists in schools.

This was our first session as the Division of Behavioral Health and Recovery (DBHR), combining the former Mental Health Division and Division of Alcohol and Substance Abuse, as well as my first in Washington State, so it was heartening to see the broad support of legislators in recognizing the vital work we and all of our community providers do. They understand the critical importance of our efforts in providing quality treatment for mental illness and chemical dependency, preventing and intervening in substance abuse and mental health problems before they become overwhelming to our clients, and in developing consumer-driven recovery-oriented systems of care.

During the 2010 Session, DBHR staff reviewed and commented on hundreds of bills and amendments, providing expertise on a very wide range of subjects linked in some way to the prevention, intervention, and treatment of mental health problems and alcohol and other drug abuse. Below are some highlights of bills related to our mission:

HB 2617 eliminates certain boards and commissions, including the Citizens Advisory Council on Alcoholism and Drug Addiction. A new mechanism will be needed to conduct the annual peer review of chemical dependency treatment programs as required under the federal Substance Abuse Prevention and Treatment Block Grant.

HB 2782, the "Security Lifeline Act," creates an integrated approach to the delivery of basic support services, education, and training programs for low-income individuals and families. Among its provisions, the General Assistance-Unemployable (GA-U) program is ended, and a Disability Lifeline Program is established, with multiple strategies to improve employment and basic support outcomes for those receiving benefits under the program:

- Individuals who are homeless and have mental health or chemical dependency (CD) problems are provided housing vouchers as an alternative to cash grants. Persons receiving housing vouchers will also receive a cash stipend of $50/month. In SFY 2008, 25% of individuals on GA-U were homeless when admitted to CD treatment.
- Individuals found in need of CD treatment will be required to participate in treatment as a condition of benefits. DBHR and treatment providers will be required to give individuals in the program high priority for admission, with first priority to pregnant women and parents.
- Penalties are established for those failing to participate in required programs.
- Benefits under the Disability Lifeline Program are limited to 24 months within a five-year period. Individuals who are terminated from benefits are provided the opportunity to complete their current course of CD treatment.

2010 Leg Session *continued on page 3*

- An "Early Supplemental Security Income (SSI) Transition Project" is created to facilitate the transition of individuals likely to be eligible for SSI. These individuals will be transferred to the "Disability Lifeline Expedited Program."

HB 2717 restricts individuals committed to DSHS custody for determination of competency to stand trial, restoration of competency for trial, or following an acquittal by reason of insanity from leaving facilities.

HB 2876 requires that, by June 30, 2011, Medical Quality Assurance Commission, Board of Osteopathic Medicine and Surgery, Nursing Care Quality Assurance Commission, Podiatric Medical Board, and Dental Quality Assurance Commission adopt new, coordinated rules related to chronic, non-cancer pain management. Rules are to include dosing criteria for the use of prescription opioids, including a dosing amount which is not to be exceeded without a consultation with a pain management specialist. Guidance will be offered on tracking clinical progress and on tracking the use of opioids.

HB 3076 revises the mental health Involuntary Treatment Act (ITA). It changes the definition of "likelihood of serious harm" to include individuals who have previously engaged in destructive behavior that is likely to be followed in the near future by an attempt to do physical harm or cause substantial property destruction. It authorizes designated mental health professionals, when making a determination regarding initial detention, to consider information providers by families, landlords, neighbors, or others. The Washington Institute for Public Policy is charged with undertaking a search for a validated mental health assessment tool to be used in assessing individuals under the ITA.

ESB 5516 provides immunity from prosecution for drug possession for individuals who seek medical attention for persons suffering a drug overdose. This "Good Samaritan" provision does not apply to charges related to drug manufacture or sale. In addition, individuals may receive, possess, and administer naloxone to an individual suffering from an apparent opiate-related overdose. DBHR will be significantly involved in information dissemination about the new statute.

ESB 6610 improves procedures related to the commitment of individuals found not guilty by reason of insanity (NGRI). A public safety review panel is established to review DSHS proposals for conditional release, furloughs, temporary leaves, or movement around the grounds of individuals found NGRI, and must complete an independent assessment and a written determination of public safety risks. DSHS may determine that an NGRI individual is not manageable in a state hospital setting and may arrange placement for such an individual in any DSHS- or DOC-operated facility, provided appropriate mental health treatment is provided.

SB 6804 authorizes DBHR to certify treatment facilities for the prevention and treatment of problem and pathological gambling, and gives the division rulemaking authority. The statute makes it possible for individuals currently employed to provide counseling to continue to practice as "agency-affiliated" counselors.

HB 2688 - 2009-10 creates a beer and wine tasting endorsement to the grocery store liquor license. The bill to allow wine tasting at Farmer's Markets, HB 2642, did not pass.

Senate Bill 6143 increases the tax on a barrel of beer from $8.08 to $23.58. Microbrews are exempt. The price of a six-pack will increase 28 cents. Taxes on cigarettes and other tobacco products are also increased, and expected to raise nearly $300 million between now and the end of the 2013 biennium.

Finally, DBHR, at the direction of the Legislature, is gearing up for the transfer of juvenile drug court services and jail-based treatment services from the Department of Commerce to occur July 1. This change is intended for Commerce to focus on economic and workforce development.

We are looking forward to continuing our work with our partners in implementing the new legislation, furthering the integration of mental health, substance abuse, and primary health care services, and establishing and strengthening recovery-oriented systems of care. Please feel free to contact me if you have any questions about the new legislative and budgetary initiatives. I also want to re-emphasize how much our success at the state level is dependent on you – a committed, dedicated, informed, and active workforce that keeps the needs of patients and communities foremost in your minds as you go about the business of working for the greater health of Washington residents and the state as a whole.

Scare Tactics in Prevention: *Do they work?*

By Lauri Turkovsky, Ph.D.

"Do scare tactics work?" The simple answer is no. "When exaggerated dangers, false information or biased presentations are delivered, teens tend to disbelieve the message and discredit the messenger (J. Beck, 1998)." But most of us understand that on some level.

Several studies have even found that fear-based appeals can backfire. When youth find information to the contrary or when fear tactics communicate a norm that "everyone does it," use rates generally remain unchanged or worse, encourage the behaviors they hope to decrease.

Generally speaking, scare tactics are affective rather than effective. Fear-based classes, assemblies and marketing campaigns may elicit an emotional or affective response. However, they have repeatedly failed to demonstrate effectiveness in reducing problem behaviors. Though there is overwhelming evidence of scare tactics' ineffectiveness, people still use them.

Giving people the benefit of the doubt, perhaps the problem is that prevention providers don't know what scare tactics are. Rather than providing a single, overarching definition, the easiest way to describe them is to give some examples. At the risk of infringing on Jeff Foxworthy's territory, it's likely a scare tactic if:

- the program makes exaggerated claims about the harm done by a behavior or the risk of harm. For instance, while death is a possible consequence of smoking, drinking or other risky behaviors, it is not inevitable. Most people know others who have used alcohol or other drugs starting in their teens, but have not experienced noticeable consequences. While there is risk associated with substance use, fear appeals can lead people – especially youth – to assume that all information about this topic presented by adults (including those in schools and government) is inaccurate.
- the goal of the campaign is to motivate behavior change through fear of consequences (such as arrest, fines, loss of license, loss of insurance).
- "Providing the facts" means telling people what they already know. Most people know smoking can lead to cancer or other health problems. Most people know that drinking and driving can lead to fatal traffic accidents. Most people know that alcohol and drug use can lead to addiction. Youth and adults often know the risks of substance use/abuse and do it anyway. If knowing the facts about harm prevented negative behavior, health care professionals would not smoke or eat unhealthy foods.

For more information about scare tactics:

- http://www.collegedrinkingprevention.gov/media/Journal/182_250.pdf
- http://www.cde.state.co.us/cdeprevention/download/pdf/Don'tDo_It_Bibiographic.pdf
- http://www.drugabuse.gov/pdf/monographs/Monograph176/Monograph176.pdf

Lauri Turkovsky is a technical assistance consultant with the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) project. She may be reached at turkolk@dshs.wa.gov.

Christine's story

By Christine M. Dorey

I'm 39 years old and have struggled with meth addiction for fourteen years. Last year I lost everything I cared about: my house, car, job, husband, and kids.

It was then when I asked for help and received inpatient treatment for 30 days at American Behavioral Health Systems in Spokane. After I completed inpatient treatment I went to Triumph Treatment Services for intensive outpatient treatment. My counselor, Ms. Sue Setter, referred me to the Access to Recovery (ATR) program, funded by a federal grant administered by the state Division of Behavioral Health and Recovery.

I was reluctant to go at first because I wasn't sure if I needed any of the services ATR provides, but I went to my scheduled appointment as suggested. My Recovery Support Specialist was Rene Prado, and she was wonderful. She explained all of the ways the ATR program could help me.

ATR helped me pay rent at the recovery house I live in, gave me a membership to the YMCA, and helped me get a Washington State identification card. But the most important thing the ATR program did for me was pay for my dental work.

Because of my addiction I hadn't been to the dentist in over 20 years. Meth had taken its toll on my teeth - I had broken teeth, infected roots and so much bone loss that I had a huge gap between my top front teeth. I was very self-conscious about this and covered my mouth whenever I laughed or smiled. All of my teeth have been repaired or replaced, and now I can smile without feeling embarrassed.

I have a new life now - I've graduated from outpatient treatment and see my kids regularly. I'm looking for employment and have been sober since March 11, 2009. I feel very fortunate to have had ATR. It truly changed my life. Thank you Rene and thank you ATR.

For information about ATR, visit: http://www.dshs.wa.gov/dasa/services/ATR/ATRMainPage.shtml.

Got FOCUS?

To continue bringing you useful information in FOCUS, let us know what matters most to you, and the drug prevention and recovery news and successes happening in your community. Send your comments and information to Deb Schnellman at deb.schnellman@dshs.wa.gov.

Advertising Rules *continued from front cover*

Summary of new rules

The new rules apply to any business or organization with a liquor license including stores, bars, taverns and restaurants in Washington. Key elements include:

- Limiting to four the number of signs advertising alcohol, brand names, and manufacturers that are affixed or hanging in the window or on the outside of the premises visible from the right of way. The rule does not apply to the business trade name or neon or other signs that are visible from the outside but intended to reach inside patrons.
- Restricting the size of alcohol signs visible from the outside of a retail licensed premises to 1,600 square inches (equivalent to 32" x 50").
- Specifying the distance from schools, places of worship, playgrounds, or athletic fields where advertising is allowed by replacing the former term "close proximity" with the new "500 feet." Advertising is allowed within 500 feet if neither the administrative body nor local authority (typically the city) objects.
- Applying the rules to signs at civic events where alcohol is served, such as beer gardens.

Studies support restricting youth exposure

Studies show that children are heavily exposed to alcohol advertising, which can lead to underage drinking. According to the 2008 Healthy Youth Survey taken by K-12 students statewide:

- 16 percent of eighth graders had at least one drink in the last month;
- 32 percent of 10th graders had at least one drink in the last month; and
- 41 percent of 12th graders had at least one drink in the last month.

The alcohol prevention community, which includes school and community-based organizations, has consistently listed limiting advertising among its highest priorities. It is also a recommendation of various studies including those by the Surgeon General, Journal of Adolescent Health and the Center for Alcohol Marketing and Youth.

For a full description of the rule revisions, please visit the Laws and Rules section of the LCB Web site at www.liq.wa.gov.

What is Traumatic Brain Injury?

By Louie Thadei

Traumatic Brain Injury | *A Life Altering Impact*

The Washington State Traumatic Brain Injury (TBI) Strategic Partnership Advisory Council reports that falls and motor vehicle crashes account for over 80 percent of TBI hospitalizations in Washington state. Motor vehicle accidents resulted in the largest percentage of TBI-related deaths (31.8%).

A Traumatic Brain Injury is caused by:

- An external trauma to the head such as a bump, blow or jolt.
- A penetrating head injury.
- A violent movement of the head such as being shaken or struck.
- A whiplash action of the head and neck that disrupts the normal function of the brain.

Not all head injuries result in a TBI, but any head injury can be the cause of a TBI. Mild TBIs, occurring again and again over days, months, or years, can result in accumulated neurological and cognitive damages. By accumulating repeated concussions, mild TBIs can become catastrophic, even fatal.

Repetitive TBIs can be caused by surviving multiple car crashes, off road vehicle jolts, or participation in extreme sports with sudden stops, drops, and falls – with or without a helmet. Also, victims of abuse who are struck frequently or shaken violently can incur repetitive TBIs.

Concussion blasts are the leading cause of TBI for active duty military personnel in war zones. For more information about TBI in the military including an interactive website for service members, veterans, and families and caregivers, please visit: http://www.TraumaticBrainInjuryAtoZ.org/ and http://www.traumaticbraininjuryatoz.org/The-Brain.aspx.

Common symptoms of a traumatic brain injury can include:

- Sudden trouble with memory, recall, concentration, attention, or thinking.
- Headaches, lightheadedness, seizures, or dizziness.
- Agitation, frustration, or outbursts.
- Blurred vision or tired eyes.
- Fatigue, lethargy, or depression.

Potential outcomes of TBI include a wide range of short or long term functional changes affecting:

- Thinking (i.e., memory and reasoning).
- Sensation (i.e., touch, taste, and smell).
- Language (i.e., communication, expression, and understanding).
- Emotion (i.e., depression, anxiety, personality changes, aggression, acting out, and social inappropriateness).

In 2005, the CDC estimated that the cost of caring for a survivor of severe TBI was between $600,000 and $1,875,000 over a lifetime. To speak with a person in Washington state about TBI services and resources, call: 1-877-TBI-1766 or find information online at www.TBIWashington.org

For more information contact Louie Thadei, Program Administrator, thadela@dshs.wa.gov.

New "Trends" Report Shows Washington's Rates of Prescription Drug Abuse Among Highest in the Nation

A new report shows that the drug-induced death rate in Washington, which has been higher than the national average for 30 years, is increasing rapidly: The 961 people who died in 2007 more than doubled the number who died in 1997.

Much of this increase stems from the misuse of prescription-type opiates. In King County alone, deaths rose from 29 in 1998 to 153 in 2008.

This is one of many new findings in the 2009 *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State*, released by the Department of Social and Health Services' Division of Behavioral Health and Recovery.

The annual report makes it possible to track trends that can mark the success of legislative efforts, a new intervention or change in public health practice, or changes in behavior. The trends may also point the way toward increased need for surveillance, research and analysis, or changes in how public services are delivered.

"Alcohol and other drug abuse costs our state $5.2 billion each year – more than the cost of cancer and obesity," said David Dickinson, Director of the Division of Behavioral Health and Recovery. "Fortunately, providing quality prevention and treatment services are proven investments that reduce health care and child welfare costs, reduce crime, and make it possible for more kids to succeed in school."

The annual Trends report provides a snapshot of alcohol and other drug use and problem gambling in the state, as well as the effectiveness of providing quality prevention, intervention, treatment, and aftercare services to Washington residents.

Other new and changing trends:

- Alcohol abuse and underage drinking continue to be Washington State's biggest drug problems; one-fifth of Washington 12th graders reported being drunk or high in school in the past year.
- Even low levels of alcohol use among women are linked with breast cancer.
- About one in eight Washington 12th graders used prescription pain relievers to get high in the past 30 days.
- In 2008, almost four in 10 admissions to publicly funded treatment for prescription-type opiate addiction were for young adults ages 18-25.
- The number of people who enter treatment within 30 days of completing detox has increased 37 percent since 2001, likely due to an increase in state-funded treatment.

The 2009 Trends Report is available online: http://www.dshs.wa.gov/pdf/HRSA/DASA/2009%20Trends%20Report.pdf

From Grief Comes Desire to be a Better Parent

By Billie McKibben MA, CDP

Victor and Rosa Pimentel were happily married when they immigrated to Tukwila, where Victor worked three jobs to make ends meet. He says, "It was my job to work for my family and Rosa took care of the girls and the home. I worked and slept and made sure everything was nice in the home for Rosa. Anything she wanted I did."

Rosa was diagnosed with cancer in December of 2008. She died in April of 2009, leaving behind Victor and two daughters, ages 12 and 7. "Now I have to do it all. I can't work nights anymore because I have to be with my girls. Things are tough now." In his grief and uncertainty of how to move forward, Victor turned to Renton Area Youth and Family Services (RAYS), which offers a free, 12-week Parenting for Success program for families.

Victor is becoming closer to his daughters. The classes show him how to communicate more effectively – an important skill for raising two pre-teen-age girls – and how to express his feelings in ways other than raising his voice. Through Parenting for Success he has met other fathers, discovered new resources, and feels he can talk about his life with people who care.

The girls miss their mother terribly but as 12-year-old Katherin says, now they know that their Dad "really cares about us."

RAYS delivers this evidence-based program in both English and Spanish. The program targets ethnic and culturally-diverse parents who are committed to raising children in a violence-free, healthy environment. Seventy-eight percent of participants are low-income, and 55 percent are ordered to attend by Child Protective Services or family courts.

In the last year, parents in the program gained knowledge and made statistically significant progress on seven of the eight Washington State Common Family Management Measures.

Parenting for Success received a Washington State Exemplary Award for Prevention Programs in 2005 from the Department of Social and Health Services' Division of Alcohol and Substance Abuse. The program is funded by the King County Alcohol and Other Drug Prevention Program and Children's Trust Foundation.

Billie McKibben, a Parent Training Coordinator with RAYS, may be reached at billiem@rays.org

CTI Mentoring

By Julia Greeson and Linda Becker

The Children's Transition Initiative (CTI) is a program for youth who are facing social or academic challenges as they transition from elementary into middle school. The goal of CTI is to keep kids in supportive services for a full year.

During the past four years, the main service has been mentoring, both school and community-based, following evidence-based mentoring protocols. In addition, family strengthening programs are available to youths' families. CTI sites are located in Spokane, Lincoln, Ferry, Island, San Juan, and Skagit counties.

The learning community formed by the CTI coordinators is a unique component of the CTI program. Coordinators meet regularly to discuss successes and challenges of their programs, including recruiting mentors, recruiting families into parenting programs, finding grant opportunities, developing confidentiality protocols, and more.

CTI sites have been participating in an ambitious evaluation pilot. Risk profiles, pre- and post-survey data, school reports, and mentor surveys are used to measure impacts after a year of mentoring. In addition, the sites and the evaluation team have tracked other prevention services available in the youths' schools and communities. Results from the pilot's first several years have indicated that mentoring is beneficial, especially in school-based behaviors. This preliminary evidence also suggests that youth who participate in multiple services benefit the most.

For more information about CTI, contact Julia Greeson, DBHR Regional Prevention Manager, at Julia.greeson@dshs.wa.gov.

The best gift you can give a child is time – free and full of heart.

Alston, a 13 year old boy, has a mentor named Keith, a 29-year- old military petty officer and a first time mentor.

Alston: *"Having Keith as a Big Brother has helped me to get better grades; from F's to C's, or higher. He's influenced me. I want to be more like him. My dad, I really don't see him. With Keith I have someone to do things with. He's lots of fun! I am glad I got matched with him; I think it's a perfect match."*

Alston's mom: *"It took a little while for Alston to trust Keith. They have a lot in common. Alston laughs a lot now – he is opening up and showing his true self. His self esteem was so low before, but now it's tremendous! He wears clothes that he likes and is not trying to impress others anymore."*

Keith: *"I wanted to give back to the community, to help someone. The best thing about being a mentor is hearing how much better Alston is doing."*

Certification Available for Problem Gambling Treatment Agencies

By Linda Graves, Problem Gambling Program Manager

As a result of the passage of Senate Bill 6804, the Division of Behavioral Health and Recovery (DBHR) will start certifying agencies to provide problem gambling treatment July 1, 2010. Certifying agencies will allow for standardization, consistency, and increased credibility in problem gambling treatment services offered throughout the state.

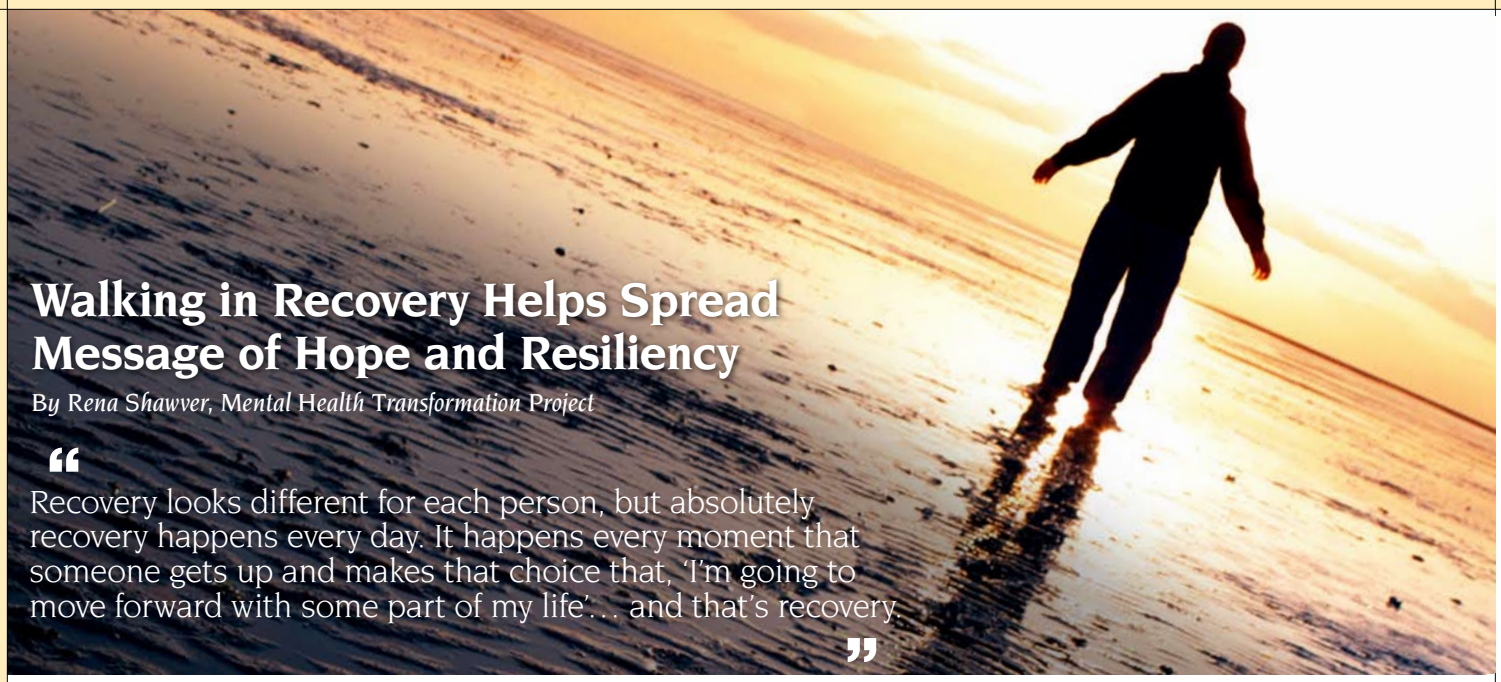
At this time, there are approximately 60 counselors in 27 locations in Washington State that provide publicly funded treatment through 21 DBHR contracts. Additionally, there are problem gambling treatment programs being implemented through private agencies and tribal behavioral health programs. The need for problem gambling treatment services continues to grow beyond the scope of resources available to the publicly funded program.

The majority of counselors who have been providing problem gambling treatment in Washington State are chemical dependency professionals (CDPs) with additional training and clinical supervision in problem gambling treatment. The scope of practice for CDPs as defined by the Department of Health does not allow them to treat problem gambling, so counselors have been treating problem gambling under a "registered counselor" designation. However, the Department of Health (DOH) is eliminating the "registered counselor" credential as of June 30, 2010.

Another designation that is in compliance with the Uniform Disciplinary Act (RCW 18.130) was needed to allow CDPs to treat problem gamblers. Due in part to legislative support, local advocacy and others involved and concerned about problem gambling treatment, Senate Bill 6804 was passed. This bill allows DBHR to certify agencies for problem gambling treatment. It also allows for CDPs working in problem gambling treatment agencies to be "agency affiliated counselors" under the Uniform Disciplinary Act in order to treat problem gambling. Counselors will still need to maintain their CDP certification with DOH in addition to the "agency affiliated counselor" designation.

Agency certification for problem gambling treatment will parallel the certification process for chemical dependency treatment. The rules are not as detailed as chemical dependency because only outpatient treatment is available in Washington State at this time. The agency applying for a problem gambling specialty will have to meet the newly established requirements of WAC chapter 388-816.

For more information about the certification of problem gambling treatment agencies, please contact Linda Graves at (360) 725-3813 or linda.graves@dshs.wa.gov.



Walking in Recovery Helps Spread Message of Hope and Resiliency

By Rena Shawver, Mental Health Transformation Project

> "Recovery looks different for each person, but absolutely recovery happens every day. It happens every moment that someone gets up and makes that choice that, 'I'm going to move forward with some part of my life'… and that's recovery."

Lori Yates enthusiastically explores why resiliency and hope are key to recovery in the new video ***Walking in Recovery***, which shares the stories of several individuals living with a mental illness and what it took for them to start their road to recovery.

"With one in four people experiencing a mental illness at any given time, it's important for people to understand recovery. We wanted a tool that anyone could use to show others what recovery looks like and that it can and does happen," says Melanie Green, who is featured in the video. Green also serves on the Social Marketing Group of the Mental Health Transformation Project (MHTP), which recently produced the video. It is now being circulated throughout the state to community mental health organizations and other key organizations supporting people with mental health issues.

In the video, Melanie shares her story of becoming ill in high school and moving in and out of the hospital while her friends went on to college. Her illness made her feel "horrible all the time." She candidly tells viewers about moving from illness to living a productive, meaningful life working and contributing to her community.

Although Melanie says there was no catalyst to her recovery, she remembers "waking up one morning in the emergency room (I was there a lot)… and it occurred to me that this is not where I was supposed to be… and I thought… 'there's something way better out there for me and I'm really going to start working it.'"

Aaron Wolfman also is featured in the video and shares his story. At age 29, Aaron had a breakdown and experienced psychotic episodes. He was later diagnosed with paranoid schizophrenia. With the support of his family, Aaron found his path to recovery through a strong work ethic and the help of medication to manage his symptoms.

Michael Hardie had a drug and alcohol problem. He didn't want to face the world; didn't want to get out of bed or go to work. When he received a diagnosis for depression, he started to see a way out of a situation that was making him miserable. He claims, in the video, that "one of the most important things in my recovery process has been personal responsibility – that I'm the one who needs to do the work."

Lonny Klugman says "the people who initiated my recovery were the people I was hanging out with…. I wanted to move away from that." After being in and out of jail, being fired from jobs and having no place to go or put his belongings, Lon decided he didn't want to live that way anymore. As he says in the video, his recovery required a whole new "everything" in his way of doing things. Lon says one of the most important things in his recovery was to "not take myself so seriously."

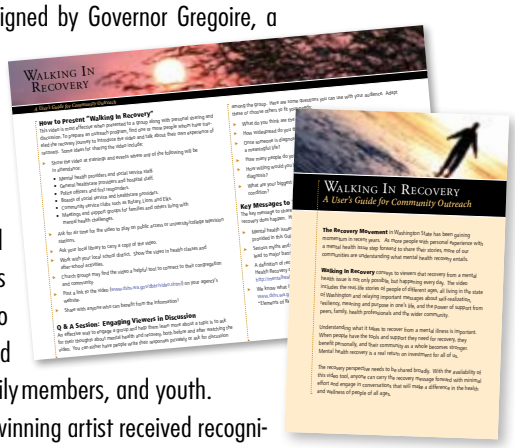
The need for support, self-awareness, hope, respect and responsibility are all components of recovery and illustrated through example in ***Walking In Recovery***.

Navos CEO David Johnson shares in the video, "As I see people move into recovery, I see them going from being focused on their medications and their symptoms, being fretful of the night. being fretful of the future, and instead, I see them much more interested in what they can create, what they are doing, who they're making laugh and who they are touching with their story."

Walking In Recovery can be viewed and downloaded for free at www.dshs.wa.gov/dbhr/video.shtml. Additionally, a Guide for Community Outreach suggesting how to use the video to spread the messages of hope, recovery, and resiliency is available at this website. The video also will be part of a workshop titled ***Walking In Recovery: Spreading the Messages of Resiliency and Recovery*** at the Washington Behavioral Healthcare Conference being held June 23-25, 2010, in Yakima.

Mental Health Month Activities

During National Mental Health Month in May, staff of the Division of Behavioral Health and Recovery (DBHR) organized several activities to increase awareness about mental health disorders and recovery among youth and adults. Activities included presentations, distributing statewide a proclamation signed by Governor Gregoire, a news release with a special emphasis on children, and a new video and discussion guide titled ***Walking in Recovery***. The video shares the stories of five individuals living with mental illness and describes what it took for them to start their road to recovery (read more about the video on page 8 in this issue of FOCUS).



The week of May 3-7 was dedicated to increasing public awareness about the triumphs and challenges in children's mental health and the importance of family and youth involvement in the children's mental health movement. A poster contest was organized for youth who are currently residing in a long-term in-patient program, to express what the theme 'Live Your Life Well' meant to them. Posters were judged by state and community mental health professionals, adult consumers, family members, and youth.

The messages in the winning poster were Shoot for the Stars and Believe. The winning artist received recognition and a T-Shirt with the poster printed on it. All youth who participated in the contest received a certificate of recognition for their expressions of topics ranging from 'advocating for yourself' to 'doing what you enjoy'. Selection was challenging as each poster carried the artist's own unique message and style reflecting the resilience of youth and their hope for a better future. The posters were hung in the Cherry Street Plaza lobby in Olympia throughout the month.

David Dickinson and Rebecca Kelly with the winning youth poster.

May 6th was designated as Children's Mental Health Awareness Day with a parent and youth from the community greeting folks as they entered Cherry Street Plaza, passing out ribbons with the message Children's Mental Health Matters, and offering a variety of printed materials and resources to promote positive mental health, well-being, and social development for all children and youth. The following messages were conveyed:

- Mental health is essential to overall health and well being.
- Serious emotional and mental health disorders in children and youth are real and treatable.
- Children and youth with mental health challenges and their families deserve access to services and supports that are family-driven, youth-guided, and culturally appropriate.
- Values of acceptance, dignity, and social inclusion should be promoted throughout all communities for children, youth, and families.
- Family and youth voice is a valued asset in determining appropriate services and interventions.

May 23-29 was Older Americans' Mental Health Week, which promotes the importance of mental health in older adults and reducing the stigma that keeps many older Americans from seeking help. Key messages from this campaign included:

- Depression is not a normal part of aging, however it is widely under recognized and treated.
- In the United States, the rate of suicide is highest among older adults.
- Older adults remain the most under-served and inappropriately served population in mental health services.

For more information about mental health, read ***Older Adult Mental Health Facts, What are Anxiety Disorders in Adults?, What is Bipolar Disorder in Adults?, What is Clinical Depression in Adults?, and What are Eating Disorders in Adults?***

Resources from the Substance Abuse and Mental Health Services Administration:

- What a Difference a Friend Makes: http://www.whatadifference.samhsa.gov/index.html
- We Can Help Us (suicide prevention site for teens): www.reachout.com

A record number of Washington advocates for the National Alliance on Mental Illness (NAMI) took to the trails of Magnuson Park in May to raise money for more programs and treatment for recovery from mental illness. 1,023 walkers and other contributors raised $163,000. For more information visit: http://www.namiwa.org

New Toolkit for Working with Children of Incarcerated Parents

By Tina Burrell, DBHR Youth Treatment Manager

If you are a chemical dependency counselor or mental health practitioner, you are currently working with youth of an incarcerated parent, or families with incarceration history, whether or not this issue has come up in treatment. That's because currently, one out of every 31 adults is incarcerated or involved in the criminal justice system (Pew 2008). In some communities this rate is significantly higher. Children and youth with parents who have prison records represent at least 15% of the youth seen in public mental health agencies.

In December, David Dickinson sent a letter to state-funded treatment programs announcing the availability of a new online resource: ***A Behavioral Health Toolkit for Providers working with Children of the Incarcerated and their Families***. This online training toolkit was developed to help practitioners respond to the special needs of children whose parents are in prison or who have been in the past.

Some of the resources you will find in the toolkit include:

- *Helpful Hints for Practitioners.*
- The *Children and Families of Incarcerated Parents Initiative in Washington State.*
- A free online training video for social service practitioners.
- Handouts for practitioners, families, and caregivers.

For many children, the traumatic experience of a sudden separation from their primary caregiver causes feelings of anxiety, anger, depression, and guilt. This can lead to emotional withdrawal, failure in school, delinquency, drug and alcohol abuse, and risk of intergenerational incarceration. It can have long-term effects on a child's mental health and increase the risk of experiencing other traumas such as neglect and exposure to domestic violence.

The tool kit is available at: http://www.dshs.wa.gov/pdf/dbhr/youthtxtoolkit.pdf. In addition to providing information to better support a child in care, the toolkit has relevant materials for other family members, caregivers, and guidance for clinicians. A limited number of printed toolkits, which included ***Tips for Providers***, a training DVD, four books, handouts, and a library resource list were distributed to the Regional Support Networks children care doordinators and residential chemical dependency treatment agencies throughout the state.

Best Practices for Mental Health Peer Support

By Kara Panek

In November 2009, the Pillars of Peer Support Services Summit was held in Atlanta to bring together states that provide formal training and certification for peer providers working in mental health systems. The goal of the summit was to examine the multiple levels of state support necessary to create a strong and vital peer workforce, and to engage in the states' efforts at system transformation, including recent innovations in Whole Health.

> "The goal of the summit was to examine the multiple levels of state support necessary to create a strong and vital peer workforce."

Included in the 25 Pillars of Peer Support are these 10 conditions that strengthen a state's Peer Specialist Certification Program:

1. Clear Job and Service Descriptions
2. Job-Related Competencies
3. Skills-Based Recovery and Whole Health Training Program
4. Competencies-based Testing Process
5. Employment-related Certification
6. Ongoing Continuing Education
7. Professional Advancement Opportunities
8. Sustainable Funding
9. Competency-based Training for Supervisors
10. Strong Consumer Movement

More details about Pillars of Peer Support can be found online: http://www.pillarsofpeersupport.org/.

In Washington, Peer Support is a Medicaid State Plan modality when provided by certified peer counselors. To date, the Division of Behavioral Health and Recovery has certified at least 265 peer counselors. Within King and Clark Regional Support Networks alone, 65 peers are currently employed providing peer support. A report of the recent survey of Washington peers who completed the state approved training is available at: http://mhtransformation.wa.gov/mhtg/articles/20091028.shtml.

Kara Panek, Mental Health Program Administrator, may be reached at Kara.Panek@dshs.wa.gov.

Help Line Reaches Another Milestone

By Ann Forbes

We are happy to announce that we reached the milestone of 750,000 calls the week of April 19, 2010. During 2009 alone, we responded to 17,419 calls, the majority coming from those ages 20-30. When we started 31 years ago in King County, we wondered if anyone would call, though we knew the need was there. We celebrated the first 100 calls, the first 500, and the first 1,000. After that we were busy keeping up with the calls.

In the early 80s, our resources were rather limited to support groups, community resource centers, inpatient treatment, recovery houses, and a few long-term residential. We operated in King County for three years, then in 1982 received funding to provide services statewide. Our referrals have continually grown as more resources became available, such as outpatient treatment, drug courts, youth outpatient, increases in private treatment centers, recovery housing and shelters.

Our phone volunteers are so vital to the Help Line by energizing us with their learning and knowledge of resources they have used on their own recovery trail. Many volunteers come from community college chemical dependency programs and the U.W. School of Social Work. During 2009, volunteers donated over 4,000 hours. We have 39 volunteers currently, with 18 on the phone and 21 in training. The volunteers are mostly women (65%), range in age from early 20s to late 50s and are ethnically diverse. They are a wonderful group to train and learn from. Volunteers commit to one year of phone work after receiving 80 hours of training.

Another resource we provide, the Chemical Dependency Jobline, has recently been redesigned, renamed, and expanded to better meet the needs of both chemical dependency and mental health professionals. It is now the Behavioral Health Professional JobLine: www.WaJobLine.com. The new site has all the features of a large career site, but with a personal focus on our field and region. We welcome any thoughts you have about the new site.

The Teen Line – www.theteenline.org is staffed by teen volunteers who provide crisis intervention and referrals for teens. You can also find them on Facebook by searching Teenline WAState. The Clearinghouse – http://clearinghouse.adhl.org/ continues to be a statewide resource for print materials and videos for teens, parents, educators, prevention and treatment professionals and related professionals. The Clearinghouse is also creating a speaker's list for community events as another resource on their website. If you can recommend speakers who only need cost reimbursement, please email Jennifer Velotta at clearinghouse@adhl.org.

Due to state and county funding reductions (major funding for Help Line services comes from the state Division of Behavioral Health and Recovery) the Help Line is in need of more private donations to keep up with the rising costs of doing business. To find out how to donate, visit: http://www.adhl.org/donate.html. We appreciate any support of the vital services needed by so many in our communities.

Ann Forbes is the executive director of the Alcohol and Drug Help Line. She may be reached at annf@adhl.org.

Washington Projects Selected for Service to Science Initiative

By Scott Waller

Two Washington State drug prevention projects were recently selected into a national Service to Science (STS) initiative that helps innovative (but promising) projects evaluate their impacts. These were among 13 projects accepted from nine western states and the pacific jurisdictions.

STS is a national initiative of the Center for Substance Abuse Prevention (CSAP) through the national Center for the Application of Prevention Technologies. Through STS, CSAP aims to increase the pool of evidence-based substance abuse prevention strategies from which states and communities can select to address specific substance abuse problems, and support innovative local interventions seeking to demonstrate and document evidence of effectiveness. STS consists of a combination of customized technical assistance, online and face-to-face tools, and financial incentives for evaluation capacity enhancement.

Abby Buennagel (left) and Lucy Bosch, Cathlamet, teach a stress management workshop as part of Wahkiakum County's Youth Mobilization Campaign.

THE TWO PROJECTS ARE:

Port Gamble S'Klallam Tribe - Revising Ordinances

The tribal prevention coalition, Chi-e-chee, has taken on the task of revising many of the tribe's ordinances. The tribal code has not been amended since the 1980s. Major modifications include changing or adding a social host ordinance, working on sentencing guidelines to bring consistency to youth, removing the right for parents to provide alcohol and developing requirements for parents to adhere to when they have a court-involved child.

Other revisions include improved language about drug paraphernalia, prescription drug abuse, classifications of multiple offenses, and developing youth classifications for criminal offenses that make fines and jail time more appropriate for youth. As part of this effort, an anonymous Tip Line has been developed to report crimes to tribal police. The Service to Science project will help develop methods for measuring the impact of these ordinance changes through 2010 and 2011.

Wahkiakum County - Youth Mobilization Campaign

The Youth Mobilization Campaign (YMC) was developed by Wahkiakum County Health and Human Services for the youth of this small, rural county in southwest Washington. They refer to YMC as their prevention "boot camp". They target three different populations in the program: peer trainers, 8th graders transitioning to high school, and adults. Through YMC, youth are paired with healthy adult role models to accomplish tasks. YMC offers participants many experiences in making decisions, dealing with stress, forms of communication, empowerment, and connecting with resources. The bonding that occurs between students and staff happen as a result of shared experiences in a natural environment away from schedules, course work, or academic rigors.

Through the Service to Science project, the National CAPT will be helping to analyze the data they have already collected and developing evaluation methods for measuring change among youth and adult participants.

Scott Waller is the Strategic Prevention Framework-State Incentive Grant Project Manager for DBHR. *He may be contacted at scott.waller@dshs.wa.gov.*

Evergreen Manor Selected for CTN Study

By Linda Grant and Betsy Wells

In March staff from the University of Washington and Evergreen Manor attended a training in preparation for a new study funded by the National Institute on Drug Abuse (NIDA) to evaluate the effectiveness of Therapeutic Education System (TES), a web-based version of the Community Reinforcement Approach plus incentives. The study will involve about 50 Evergreen Manor outpatient clients.

Ten abstinence-based community programs from the NIDA National Clinical Trials Network (CTN) were chosen to participate. The University of Washington Alcohol & Drug Abuse Institute, headed by Dr. Dennis Donovan, is responsible for the Pacific Northwest Node of the CTN and works with several Washington treatment programs to enhance the bidirectional dissemination of information between community treatment programs and researchers.

TES is an interactive, self-directed Community Reinforcement Approach delivered through 65 interactive, web-based multimedia modules. Modules include topics such as relapse prevention skills, managing thoughts about drug use, coping with anger, relationship counseling, time management, negotiating safer sex, taking responsibility for chances, sharing feelings, insomnia, and receiving criticism. There are also modules related to the prevention of HIV, hepatitis and sexually transmitted infections.

Interactive videos show actors modeling various behaviors for the program user, exercises to enhance learning, and personalized content. An electronic reporting system within TES allows therapists to view summaries of their patients' TES activity and progress, recommend modules to be covered, and integrate patients' use of TES into their counseling sessions. In this way, TES can function as a clinician-extender as well as a flexible system for tracking and reinforcing target behaviors such as abstinence.

In this research study, half the clients agreeing to participate in the study will be randomly assigned to typical intensive outpatient programs (TAU), and half will be randomly assigned to the TAU+TES. Those in TAU+TES will have two hours of computer modules substituted for two hours of the outpatient group lectures. In addition, the TAU+TES clients will be given recognition and prizes for incremental and continued abstinence. Approximately 500 clients nationwide will participate in this randomized study.

If found effective, TES has the potential benefit of offering wide access to treatment basics, reducing counselor time, and improving client engagement. More information about this project can be found online: http://ctndisseminationlibrary.org/protocols/ctn0044.htm.

Linda Grant is the Executive Director of Evergreen Manor. She is particularly interested in this study because of the progressive use of technology in clinics and by clients. Betsy Wells, Ph.D., is the Principal Investigator with the UW School of Social Work & ADAI.

Left to right: Linda Grant; Danielle Shandera, EM Research Coordinator; Betsy Wells; Sharon Garrett, UW/RRTC Project Manager; Lindsay Jenkins, UW/RRTC Regulatory Specialist; Janet Walthew, EM Research Assistant; Clay Eakin, EM Clinical Supervisor

In Memory of Stan Timberlake

Stan Timberlake, an outreach services representative for Oxford Houses of Washington, passed away on January 11. Stan worked with Oxford Houses for five years, and also served on the planning committee for the Warm Beach Conference in Region 3 and 4.

Stan will be greatly missed not only by his peers, co-workers, and staff from Division of Behavioral Health and Recovery but by anyone that has ever had any interactions with him. He was passionate about recovery, Oxford House Principles, and life.

For more information about Oxford House, visit www.oxfordhouse.org.

National Guard Weekend Provides Resources for Returning Soldiers

By Heidi Dodd

"In war, there are no unwounded soldiers." — *José Narosky*

This quote speaks to the reality returning soldiers from Iraq and Afghanistan are experiencing. In response, stakeholders statewide are working on providing critically needed resources and services for soldiers with the Washington National Guard (WNG). We in the civilian world are not typically aware that WNG soldiers returning to the States only receive medical benefits for 90-180 days after return from deployment, regardless of the number of times they've been deployed.

In an effort to support the WNG, and after several months of collaboration and coordination between the Division of Behavioral Health and Recovery's (DBHR's) Access to Recovery Program, Lifeline Connections, Safe Harbor Recovery Center, and New Horizon Care Center; nine Chemical Dependency Professionals (CDPs) volunteered their expertise to provide assessments and education to WNG veterans identified as possibly needing treatment for substance use.

The National Guard Weekend was held February 26, 27, 28, at Camp Murray near Tacoma. The first day consisted of the CDPs participating in military cultural awareness training, touring the J9 and Alcohol and Substance Abuse Program (ASAP) units, and learning about the Wounded Warrior Program. The J9 unit is designed to provide valuable resources to soldiers and their families such as suicide prevention and awareness information, sexual harassment and assault awareness, employment search skills and job placement, and financial assistance. The ASAP unit provides chemical dependency and mental health treatment services for both guardsmen and Army veterans.

When the soldiers arrived, they were given a urinalysis and the day's agenda was explained to them. The highlight of the morning was a very personal and passionate story by Colonel Kern who shared with the guardsmen his plight with alcohol, drugs, and violence. It was a very moving experience for the soldiers to see and hear that someone of such rank had difficulty with substances, overcame this, and has been in recovery for 30 years. After the presentation, soldiers were assessed for substance use and provided with local resources for services in their communities.

The counselors participated in a focus group to identify areas of concern with providing evaluations and referrals to veterans who may have special needs but no means for getting help. Many of the CDPs said the weekend was a powerful experience for them; all except one had served in the military or were married to someone in the military. By volunteering their services for the weekend, they felt they were giving back to their country in a small way.

Jackie Blair's Experience (National Guard Weekend CDP)

I was in awe of the struggles that the Guardsmen go through for our country. I was disappointed when I realized we do not take care of these soldiers returning to their communities. They often do not have jobs to return to and no private insurance. The Guard will cover them for medical services for 180 days and that's all. The alcohol and drug use often appears to stem from their need to self-medicate from the horrific things they experience and see when deployed to Afghanistan or Iraq.

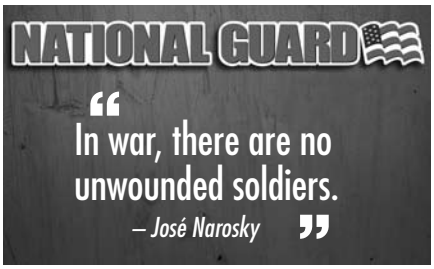
I was honored to have this experience and training and so appreciate DBHR's program and their forward thinking to use ATR III money to help servicemen who fall through the cracks and need treatment. My favorite new word I learned was "hot UA" (to describe a urinalysis that's positive for drug use).

A second National Guard Weekend will occur July 9, 10, and 11. DBHR is looking for up to 12 volunteer CDPs to participate. Volunteers need agency approval as the completed assessments must be recorded by their agency. To volunteer, or to find out more about these trainings, contact Heidi Dodd at Heidi.Dodd@dshs.wa.gov or Cheryl Wilcox at Cheryl.Wilcox@dshs.wa.gov.

Post-traumatic Stress Disorder (PTSD)

Anyone can develop PTSD if they have experienced, witnessed, or participated in a traumatic occurrence — especially if the event was life threatening. The psychological damage such incidents cause can interfere with a person's ability to hold a job or to develop relationships with others. The symptoms of PTSD can range from constantly reliving the event to a general emotional numbing. Persistent anxiety, exaggerated startle reactions, difficulty concentrating, nightmares, and insomnia are common. Treatment can help people with PTSD regain a sense of control over their lives (source: SAMHSA's Center for Mental Health Services).

Heidi Dodd is a regional prevention manager with DBHR.



INFORMATION AND REFERRAL SERVICES FOR VETERANS

National Center for PTSD
Provides fact sheets, guides, and treatment information on PTSD and stress-related disorders from the VA. www.ncptsd.va.gov

SAMHSA Veteran Resource page
www.samhsa.gov/vets

Military OneSource
A 24/7 resource for military personnel and their families on a variety of topics, including health, legal, and family concerns.
1-800-342-9647
www.militaryonesource.com

Treatment Locators

Washington State Alcohol and Drug Help Line:
1-800-562-1240

SAMHSA's 24-hour Referral Helpline for substance abuse and mental health services at 800-662-HELP (4357), or find treatment online.

SAMHSA's Substance Abuse Treatment Facility Locator:
www.findtreatment.samhsa.gov

SAMHSA's Mental Health Services Locator:
www.mentalhealth.samhsa.gov/databases

Tara's Story

Skagit Recovery

Recovery has been a crazy journey for me. The day before I went into treatment I thought to myself, "I'm going to use drugs for the rest of my life." I woke up to use and used until I passed out, I was hopeless. I went to treatment on January 29, 2009. I overdosed two days before treatment and that was not the first time. I don't really know exactly what it was that made me want to stop using, but something happened.

In my use I was beaten, raped, and kidnapped. I stole from people who I loved immensely and from people who I didn't even know. I remember the day of going into treatment, getting so high and drunk, and just crying so viciously. I remember feeling tired, alone, sad, suicidal, and helpless. I hated myself so bad that I don't think it could have gotten much worse. I woke up one day and just started to feel emotion, raw emotion, and I hated feeling anything, it was like I could feel everything. The look in my father's eyes as I was crawling on my knees, screaming, and begging him for help, killed me. He did not know what to do, and my dad always knew what to do.

So I went to Lakeside Milam, Recovery Center (LMRC) in Burien, Washington. Going into inpatient I just wanted to quit doing meth, crack, and liquor. I did not know that the program is all or nothing.

On February 22, 2009, my father passed away. I was so shocked; I could not believe my father could just die. Just be gone. A person like a parent who has so much responsibility, they have so many things to be taking care of, just gone one day. He was my father, my rock, and my provider. I wanted to use so bad, but my counselor from LMRC and all of the staff there was right behind me giving me all the support I could handle at the time. My counselor had told me about a place called John King Recovery House (JKRH), he told me it was a recovery house for teens. I flip flopped the idea in my head and thought, "What could I really learn there? I am 16 and I already know everything." But my counselor helped to wipe that thought out of my head and helped me to realize that the only way I would stay clean was to go to JKRH.

I went from Burien to Mt. Vernon, Washington. When I got there I remember it was cold, there were kids playing basketball outside, kids inside watching TV. I was so scared and intimidated, but covered it with excitement.

Dean was the first person I remember there. He said to me, "Happy to be here? Do you have any behavioral problems?" I said, "No, not at all." Dean smirked and said, "Well as long as you stay away from the boys and follow the rules, we will get along just fine."

I went to JKRH with no ability to have relationships, I did not know how to properly converse, I was just a liar and a cheat. A broken teenager. JKRH helped me to fix all of that. JKRH is such a wonderful place to be, it is such a healthy support group there. I was shown a new way of life. No more despair, a life of freedom, happiness, structure, and I actually look forward to waking up in the mornings now.

I have groups on Monday through Thursday, I go to school five days a week, clean my room, go to meetings, have positive role models in my life, and even eat three meals a day! Without having gone to JKRH and especially the guidance from my counselor Dean, I know for a fact I would be loaded on drugs right now. I would not have known what to do with my emotions if I did not take the time to stay and learn how to function without drugs. I have been shown through my stay here how to live life, and I am being integrated back into the real world with morals, healthy values, and can now make responsible choices with healthy relationships. I feel now that living my life to its fullest is getting an education, having a family, being productive and responsible, and being active in my community. I can actually have fun doing things that a normal teenager does.

JKRH has taught me more tools to deal with my emotions and problems than I have ever learned in my entire short life. Dean, Katie, Trina, Kay and Alan have played the largest role in my recovery here. They gave me support, care, and a second chance at life. I now have self-respect, which is amazing considering where I was seven months ago. I now believe there is more to life than shooting dope and drinking liquor.

I can do whatever I want; I can be whoever I want to be. Having a counselor that I could talk to whenever I needed to has helped me more than anything else. Dean did not agree with me and felt sorry for me when I came to him crying, sulking with problems, and grief. He helped me to decipher a solution. JKRH gave me everything I needed for a foundation in my recovery. JKRH is the best thing that ever happened to me, it has been the happiest and hardest six months of my life.

I learned that I will feel down, sad, angry, and mad, but that I will never feel one way forever. My happiness is dependent on me and what I am willing to do to pull myself out of it. Misery is optional and faith is a must. One day at a time I can stay sober for the rest of my life. I live in recovery now, I am not just sober. JKRH and all of the staff there taught me all of that. They helped restore me to a happy girl, someone who does not just give up and take the easy way out. I do not think any of the staff there gets enough credit for the job they do. JKRH "Saved My Life" and it is because of all the staff there.

Now I am 17 years old, I have realistic morals and values. I have seven months and twelve days clean and I am looking forward to every day of the rest of my life.

– Tara C.

Upcoming Events

For training details and registration, see DBHR's online Training Calendar at www.dshs.wa.gov/dasa/services/training/calendar2009.shtml

27-29 WELLNESS RECOVERY ACTION PLAN
Spokane, WA
Information available here
Registration form available here

13 NAMI STATE CONFERENCE
Ellensburg, WA
360-584-9622 or
office@namiwa.comcastbiz.net

17-19 WELLNESS RECOVERY ACTION PLAN
Wenatchee, WA
Information available here
Registration form available here

NATIONAL ALCOHOL AND OTHER DRUG ADDICTION RECOVERY MONTH
www.recoverymonth.gov

14-16 WELLNESS RECOVERY ACTION PLAN
Mt. Vernon, WA
Information available here
Registration form available here

17-19 COUNSELOR CAMP
Randle, WA
Registration information available here
Call 425-485-7396
Or email julie@riteofpassagejourneys.org

Share news about your prevention, intervention, treatment, and aftercare program. If you have events, success stories, announcements, or a policy/advocacy issue you want to write about, email Deb Schnellman at deb.schnellman@dshs.wa.gov, or call 360-725-3763.

The Power of the Media and its Impact on Mental Health Recovery

By Rena Shawver, Mental Health Transformation Project

One newspaper article or broadcast story can be highly influential to a community. Over the years, the media unknowingly has painted an often inaccurate picture of mental illness, shaping public attitudes that contribute to barriers for successful recovery. To help Washington State reporters shape a more accurate public view of people with mental illnesses, the Washington State Coalition for Mental Health Reporting has formed to support the media in their need for accessible sources and factual information.

"The work of the coalition is really two fold, " says Jennifer Stuber, Ph.D., with the University of Washington School of Social Work, who is spearheading the work of the coalition through a grant from the Mental Health Transformation Project (MHTP). "First, reporters need access to people in the mental health community – consumers, peers, family members and professionals – to interview and share their stories to build a better public understanding of mental health issues. Second, reporters need an ongoing dialogue with credible sources to help keep them informed, create an accurate public record and better represent the realities of mental health issues."

Stuber hopes that the newly formed coalition will be able to fill some of the needs of reporters. She has spent the last year traveling around the state conducting media trainings for people interested in being part of the coalition and meeting with news room reporters and editors to discuss how the use of certain language and the link to violence in articles referring to mental illness influence decisions around housing, employment, policies, and even relationships which are all key factors to recovery.

"Reporters have been very receptive to hearing how their words shape attitudes," says Stuber whose work on this issue recently earned recognition from the Robert Wood Johnson Foundation as an international "Changemaker" for social reform. Additionally, her advocacy has been awarded recognition locally by Valley Cities Counseling and Consultation, a community mental health organization in South King County.

The impetus to form the coalition was original research Stuber conducted by tracking news reports in daily papers throughout Washington, studying nearly 1,000 articles over a ten-year period and laboriously coding content such as word choices and links to violence. Her results supported the inaccuracies of local reporting on topics related to mental illness. She continues to monitor state-wide media on a daily basis, engage in conversations with reporters, write letters to the editors and opinion pieces, as well as encourage reporters to write on topics that include interviews with people living with mental illness.

"There is still a great deal of discriminating language in use today in our society and this is highly stigmatizing to this population," says Stuber. She points out that the media is not solely to blame for an issue that is systematically engrained in society. "Reporters reflect the views of the community when they write about something, so it's important to educate the community about model language to start changing the cycle." Stuber's work is gaining national attention as well. She recently participated in a national training teleconference hosted by the Substance Abuse and Mental Health Services Administration (SAMHSA) and co-presented the Coalition's work along with presenters Otto Wahl, PhD, author of ***Media Madness: Public Images of Mental Illness and Telling is Risky Business: Mental Health Consumers Confront Stigma,*** and Bob Carolla, JD, Director of Media Relations for the National Alliance on Mental Illness (NAMI). The original teleconference, held on March 26, 2010, can be heard by going to http://www.promoteacceptance.samhsa.gov/teleconferences/archive/default.aspx.

Additionally, Stuber helped publish a ***Guide for Mental Health Reporting*** for reporters, similar to guides for reporting on other disabilities: http://mhtransformation.wa.gov/MHTG/mediaToolkit.shtml.

She hopes to continue to expand the network of people interested in supporting the work of the coalition and is seeking local and national grant money to sustain the project, which was originally funded with a start-up grant from the MHTP.

The MHTP operates out of the Office of the Governor and receives grant support from SAMHSA. Washington is one of nine states to receive a SAMHSA transformation grant. One of the key goals of the statewide effort is to engage consumers, family members, and partners in a deep transformation effort to improve the state's mental health services and delivery system, ultimately serving as a model for the nation.

For more information on the Washington State Coalition for Reporting on Mental Illness, go to www.mentalhealthreporting.org.